**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered services.**

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation. (2010-138, s. 1.)